Issues in Postabortion Care:
Scaling-Up Services in Francophone Africa

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For further information or copies, please contact:

SARA Project
Academy for Educational Development
1825 Connecticut Ave., NW, Suite 900
Washington, DC 20009-5721 USA
Tel: 202.884.8000
Fax: 202.884.8400
Email: sara@aed.org

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Foreword

It has been widely documented that consequences and complications from unsafe abortion cause a large number of maternal deaths. A 1999 World Health Organization (WHO) study estimated that the direct causes for 18 percent of these deaths could be attributed to abortion complications. In sub-Saharan Africa, the problem is compounded by the continuing unmet need for family planning. Given that most abortions are under reported, the problem is very serious and deserves more attention.

While more attention has recently been paid to the effects of abortion complications (or, alternatively, the effects of unsafe abortion) in Francophone Africa, the policy environment surrounding care for abortion complications in this region is not particularly favorable; often, the issue is not perceived as a health priority at the national level. Efforts to increase access to and quality of services for abortion complications are usually limited to small pilot programs, which, despite their promise, often fail because of policy or programmatic hurdles.

In recent years, ministries of health in several countries in West and Central Africa have begun to pay more attention to the problem of abortion complications and are looking to introduce postabortion care (PAC) services. Complete PAC services include emergency medical treatment of women who suffer abortion complications, family planning (FP), and other appropriate reproductive health (RH) care. Documentation of programs that offer complete PAC services shows a considerable unmet FP need among clients who have undergone abortions; it is intended that PAC services increase use of contraception among PAC clients.

PAC services, including the use of the manual vacuum aspirator (MVA), have been introduced on a limited basis in a few Francophone countries in Africa. Operations research has been an effective way to launch and gain support for PAC activities in this region. It has also promoted South-to-South collaboration in this sensitive area. Research study results of pilot programs in Burkina Faso and Senegal produced the data necessary to convince service providers and decision makers in health ministries in West and Central Africa to introduce and support PAC programs.

To begin providing responses and programmatic solutions to PAC issues, a consortium of international and regional agencies and projects, including the Centre de Formation et de Recherche en Santé de la Reproduction (CEFOREP); the Advance Africa, Frontiers in Reproductive Health (FRONTIERS), POLICY, PRIME, and Support for Analysis and

Research in Africa (SARA) projects; EngenderHealth; Family Care International; Ipas; JHPIEGO; Population Council; Population Reference Bureau (PRB); the Swedish International Development Agency; the U.S. Agency for International Development (USAID); and WHO proposed to play a catalyst role in establishing a committee to implement a regional Francophone PAC Initiative. The principal purpose of the initiative is to promote increased access to and quality of PAC services in Francophone Africa. The three main objectives of the initiative are to:

- Create a favorable policy environment to introduce and extend PAC services;
- Evaluate, document, and disseminate in Francophone Africa principal lessons learned in implementing PAC services in the region and globally; and
- Encourage South-to-South exchange of technical expertise and experiences in creating and scaling up PAC services.

The central activity of the initiative was a major four-day conference held at the Hotel Meridien Président in Dakar, Senegal, March 4-7, 2002. The global partners for this activity were Ipas, the International Planned Parenthood Federation, the Ford Foundation, the David and Lucille Packard Foundation, the Rockefeller Foundation, UNFPA, and WHO. The conference aimed to disseminate groundbreaking information on PAC work conducted in Burkina Faso, Guinea, and Senegal, where services were introduced at the national level and extended to regional hospitals, and in Ghana, where PAC services have been decentralized to the primary healthcare level. The committee hopes that disseminating these experiences will result in their adoption, adaptation, or replication in several countries in the region. The conference's ultimate goal was to establish sustainable and accessible quality PAC services in the region.

This report summarizes core issues in taking PAC services to scale in Francophone Africa. It serves to complement the report from the international PAC workshop held in Mombasa, Kenya, in May 2000; as such this report focuses on discrete issues, though some overlap is necessary. Participants gathered to learn from each other and generate practical actions plans to expand PAC in their countries. Beyond the conference, the regional committee and resource persons pledged their continued support to reduce the performance gaps that still exist among both providers and health systems for optimal delivery of quality PAC services. To help maintain the momentum, the conference organizers and members

of the Francophone PAC Initiative Committee urge the United Nations Population Fund (UNFPA), USAID, WHO and other institutions to help intensify the call to action.

We hope future reporting will show increases in the percentages of women who, after having an abortion, are counseled in FP and subsequently accept a modern contraceptive method to space or limit pregnancies and increases in clients referred to or provided with other RH services. The role of regional institutions such as CEFOREP, the Society for African Gynecologists and Obstetricians (SAGO), and others will be critical as we continue to document the impact of the Francophone PAC Initiative on the availability and quality of PAC services particularly as it relates to decentralized health care.

Pape Gaye
IntraHealth

Acknowledgments

The Francophone PAC Initiative Committee acknowledges the vital roles played by Placide Tapsoba (Population Council) and Pape Gaye (IntraHealth); without their enthusiasm and tireless commitment to this cause, this committee would not have been created. As PAC champions, they engineered the initiative, secured funds for the conference, and galvanized the creation of an informal network of USAID cooperating agencies, regional and international organizations, and national partners that started a dialogue on the need to promote the development of PAC services in Francophone Africa.

Following the conference, the Francophone PAC Initiative Committee asked USAID's Bureau for Africa and the SARA project to coordinate this report, which provides guidance on lessons learned in PAC program implementation for program planners and managers. This report does not include the presentations given at the Dakar conference but provides a more in-depth analysis on PAC programming issues in Francophone Africa. The following individuals contributed to the writing of this report: Pamela Bolton (Family Care International), Nadine Burton (Ipas), Issakha Diallo (Advance Africa/Management Sciences for Health), Rouguiatou Diallo (Ipas), Thierno Dieng, (CEFOREP), Pape Gaye (PRIME/IntraHealth), Norine Jewell (POLICY/Futures Group International), Celeste Marin (FRONTIERS/Tulane University), Seipati Mothebesoane-Anoh (WHO/AFRO), Elizabeth Ransom (Population Reference Bureau), Amy Rial (JHPIEGO Corporation), Holley Stewart (SARA/Population Reference Bureau), Marcel Vekemans (PRIME/IntraHealth), and Ellen Wertheimer (PRIME/IntraHealth).

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Acronyms and Abbreviations

AIDS	Acquired immune deficiency syndrome
CEFOREP	Centre de Formation et de Recherche en Santé de la Reproduction (Center of Training and Research in Reproductive Health)
COPE	Client-oriented, provider-efficient
CRESAR	Cellule du Reseau de Recherche en Santé de la Reproduction en Afrique (Chapter of Reproductive Health Research Network in Africa)
D&C	Dilation and curettage
EOC	Emergency obstetric care
FP	Family planning
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development, Cairo, 1994
JHPIEGO	Johns Hopkins Program for International Education on Gynecology and Obstetrics
MH	Maternal health
MOE	Ministry of education
MOH	Ministry of health
MVA	Manual vacuum aspiration
NGO	Nongovernmental organization
OB/GYN	Obstetrics and gynecology
OJT	On-the-job training
OR	Operations research
PAC	Postabortion care
PI	Performance improvement
PNP	Policies, norms, and protocols
PRB	Population Reference Bureau
RH	Reproductive health
SAGO	Society of African Gynecologists and Obstetricians
SARA	Support for Analysis and Research in Africa project
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1

Introduction

The Magnitude of the Problem

Worldwide, an estimated 500,000 girls and women die every year from pregnancy-related causes—120,000 of them from West and Central Africa alone. For every girl or woman that dies, an estimated 20 to 30 experience severe problems. Data on the proportion of these deaths and injuries resulting from unsafe abortion are limited. Estimates range from 18 to 50 percent of all maternal deaths, while millions of girls and women are believed to suffer permanent health damage from complications related to abortion. Tragically, these deaths and injuries are largely preventable. Beyond the high human toll, the weak health-delivery system in Africa is extremely burdened by the treatment of abortion-related complications, which often require several days of hospitalization and consume precious staff time and scarce medical supplies.

As many as 20 percent of all pregnancies end in spontaneous abortion—also known as miscarriage (Maternal and Neonatal Health Program, 2002). Spontaneous abortions, if incomplete or otherwise complicated, can also cause injury or death. The most common cause leading to induced abortions is unwanted pregnancy. It is estimated that one-third of pregnancies in Africa, 12 million per year, are unwanted or unplanned (Alan Guttmacher Institute, 1999). This underscores the gap between demand and availability of contraceptive methods and effective contraceptive use—namely, limited access to a full range of family planning (FP) methods, services, and information and contraceptive failure. The average contraceptive prevalence for all modern methods in sub-Saharan Africa is estimated at 13 percent, the lowest of all developing regions (Population Reference Bureau, 2002b).

Many unwanted and unplanned pregnancies in Africa are also related to the early age of sexual activity. Although most societies consider marriage a precondition for sexual intercourse, substantial proportions of adolescents begin having intercourse before they marry, and young females often report that their first sexual experiences are either forced or coerced by older partners. With limited access to reproductive health (RH) care and social norms proscribing premarital pregnancy, many adolescents with unwanted pregnancies feel abortion is their best option. In many African countries, 70 percent of women treated for abortion complications are younger than 20 (World Health Organization, 1997).

Additionally, sexual violence, including rape, often results in unwanted pregnancies. Consequently, a large number of girls and women have unintended pregnancies because they have been deprived of choice regarding sexual activity and contraception.

The Conference

To reduce the morbidity and mortality from abortion complications and improve women's access to postabortion care (PAC) services, the Francophone PAC Initiative was launched to build upon efforts to address PAC in Francophone Africa. Placide Tapsoba (Population Council) and Pape Gaye (IntraHealth) created the initiative and worked tirelessly to champion and fund a four-day PAC conference: *Reducing Maternal Mortality through Postabortion Care: A Workshop For Francophone Africa*. Held in Dakar, Senegal, March 2002, this conference brought together representatives from a dozen West African nations to highlight issues related to abortion complications and to strategize about how to reduce maternal mortality by providing PAC. The conference was organized by a consortium of nongovernmental organizations (NGOs) and U.S. Agency for International Development (USAID) cooperating agencies in collaboration with the World Health Organization and health officials from the participating countries (Benin, Burkina Faso, Cameroon, Central African Republic, Côte d'Ivoire, Ghana, Guinea, Haiti, Madagascar, Mali, Niger, Rwanda, Senegal, and Togo). The conference provided a forum to share best practices and country experiences in providing PAC. It aimed to assist countries in defining strategies to introduce and strengthen quality PAC services. Delegates had much to learn from one another because the countries in the region are at different stages in developing service-delivery systems, consolidating community and political support, and codifying standards through national legislative processes.

The conference began with a one-day "mini-university" consisting of four periods with four concurrent sessions each. Delegates from each country team split up to attend as many of the 16 sessions as possible. The remaining three days were divided into plenary sessions and a series of concurrent roundtable discussions on specific PAC topics. Finally, the representatives from each country met to develop an action plan for introducing or expanding PAC in their country.

To raise the profile of PAC issues throughout the region and to facilitate effective news coverage, the Francophone PAC Initiative Committee organized two preconference briefings on PAC for journalists, who represent a powerful communications tool for reaching decision makers, opinion leaders, and the public. However, covering population and health-related topics well requires some knowledge of the topics, access to high quality information, and story ideas on a regular basis. The purpose of the briefings was to educate journalists on writing knowledgeably about safe motherhood and, in particular, the complex topic of PAC. Journalists learned about PAC and its legal and political contexts and received an overview of the conference and its goals.

During the conference, the journalists received PAC press kits and had access to a media center equipped with telephones and computers with internet connections, enabling them to file their stories immediately. The journalists participated in every part of the conference, including the mini-university presentations, plenary sessions, and country action plan meetings. Collectively, these journalists wrote 16 articles and produced seven radio stories for local newspapers and news services.

The technical content of the conference focused on three main themes:

- Knowledge and skills of health care providers;
- Integrating PAC into national RH programs; and
- Policy and advocacy.

These are also the themes of this analytical report on PAC in Francophone Africa. Written jointly by the conference facilitators, this report shares the content of the PAC meeting in an expanded form, offering more depth and detail than was possible during the actual sessions.

Components of Postabortion Care

The original PAC model had three components (Ipas, 1991):

- Emergency treatment services for complications of spontaneous or unsafely induced abortion;
- Postabortion FP counseling and services; and
- Links between emergency services and comprehensive RH care.

In 2002, the PAC Consortium, a multiagency working group that seeks to advance PAC throughout the world, developed and adopted an expanded PAC model that focuses on training and equipping clinicians to perform uterine evacuation with manual vacuum aspiration (MVA)*, expanding services to decentralized service delivery points, and linking treatment with FP and other kinds of RH care.

The expanded and updated PAC model adds the community as an essential element and acknowledges that a strong and effective partnership between community members and health care providers can strengthen efforts to reduce maternal mortality and morbidity caused by abortion complications. The new model also highlights counseling as an essential element on its own—counseling that addresses FP and contraceptive education as well as the emotional and physical needs of a woman who is experiencing abortion complications. The five essential elements of the expanded PAC model are illustrated in Figure 1 on the opposite page.

For the purpose of this report, the original three-element model will be used because it was the standard international model at the time of the conference and the one on which discussions and strategies were based. It was also the framework for PAC that had been promoted and adopted in Francophone African countries. However, nothing described in the five-element model is new. The PAC Consortium has simply made more explicit certain aspects (community and counseling) that were implicit in the first version. Indeed, this conference devoted significant attention to advocacy and collaboration with local organizations, despite the absence of a specific "community" element in the model.

* USAID does not support the purchase and distribution of MVA kits for any service.

Figure 1
Essential Elements of Postabortion Care

Community and service provider partnerships	Prevent unwanted pregnancies and unsafe abortion Mobilize resources to help women receive appropriate and timely care for complications from abortion Ensure that health services reflect and meet community needs and expectations
Counseling	Identify and respond to women's emotional and physical health needs and other concerns
Treatment	Treat incomplete and unsafe abortion and potentially life-threatening complications
Contraceptive and family planning services	Help women prevent unwanted pregnancy or practice birth spacing
Reproductive and other health services	Preferably provide onsite or via referrals to other accessible facilities in providers' networks

Source: Postabortion Care (PAC) Consortium Community Task Force. (2002).

2

The Legal/Policy Context

During the International Conference on Population and Development (ICPD) held in Cairo in 1994, governments of the world recognized abortion complications as a major public health concern and pledged their commitment to reducing the need for abortion through expanded and improved family planning (FP) services. Country delegates noted that prevention of unwanted pregnancies must always be given the highest priority, and every attempt should be made to eliminate the need for induced abortion. In all cases, women should have access to quality services for managing abortion complications. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. These changes should ensure that there are no punitive measures taken against women treated for complications.

Abortion Laws and Policies in Sub-Saharan Africa

Abortion laws differ among countries, and, in many cases, they offer little or no guidance on the circumstances in which abortion is not a criminal offense (see Table 1 on the following page). In sub-Saharan Africa, several countries either prohibit abortion altogether or only permit it to save a woman's life. Some countries permit abortion to protect the physical or mental health of a woman on socioeconomic grounds, when the fetus is impaired, or when the pregnancy is the result of rape or incest. Nonetheless, country delegates who committed to the ICPD and the Fourth World Conference on Women in Beijing declarations all agreed to provide postabortion care (PAC) services regardless of the legal status of abortion in their countries (Beijing Declaration and Platform for Action, 1995; Report of the United Nations International Conference on Population and Development, 1994).

Table 1

Illustrative Data on Country Abortion Policy, Fertility, Modern Contraceptive Method Use, and Maternal Mortality Rates in West Africa

Country	Total fertility rate[1]	Percentage of women 15-49 using modern contraceptive methods[1]	Maternal deaths per 100,000 live births[2]	Abortion policy[3]
Benin	6.3	7	880	C
Burkina Faso	6.8	5	1400	C
Cape Verde	4.0	46	190	D
Chad	6.6	2	1500	C
Côte d'Ivoire	5.2	7	1200	A
Gambia	5.9	9	1100	C
Ghana	4.3	13	590	C
Guinea	5.5	4	1200	C
Guinea Bissau	5.8	4	910	A
Liberia	6.6	—	1000	C
Mali	7.0	6	630	B
Niger	7.5	4	920	A
Nigeria	5.8	9	1100	A
Senegal	5.2	8	1200	A
Sierra Leone	6.3	4	2100	C
Togo	5.8	7	980	A

A: Prohibited or permitted only to save a woman's life
B: Permitted only to save a woman's life or in special cases (e.g., rape); spousal/parental consent may be required
C: Permitted on physical or mental grounds and in special cases; spousal/parental consent may be required
D: Permitted on broad socioeconomic grounds and health grounds with gestational limits

Sources: [1] Population Reference Bureau. (2002b).
[2] Population Reference Bureau. (2002a).
[3] Center for Reproductive Rights. (2003).

Since 1995, five countries in the region have enacted legislation increasing access to abortion: Benin, Burkina Faso, Chad, Guinea, and Mali. In 1996, Burkina Faso amended its penal code to permit abortion at any stage of pregnancy when a woman's life or health is in danger or in cases of severe fetal impairment. Abortion is also permitted during the first 10 weeks of pregnancy in cases of rape or incest. Under the previous law, abortion was prohibited unless performed to save a woman's life (Center for Reproductive Law and Policy, 2000).

Policy Environment

A policy environment is composed of many elements, including laws and policies, the will of leaders to address problems, the mobilization of material and financial resources at the national and subnational levels, the impetus for action to implement solutions, institutional structures to ensure long-term and sustainable programs, and support among key stakeholders in the public and private sectors and civil society.

As measured against the framework provided by the ICPD recommendations, the region faces many challenges, the foremost of which is weak political commitment to reproductive health (RH), including PAC. This is most evident in the lack of forceful, coherent actions to address high maternal mortality and the unmet FP need that fuels the problem of abortion complications. A weak FP/RH program also undermines a compelling and effective strategy in PAC advocacy—situating PAC squarely within an overarching safe motherhood program. Furthermore, political commitment at the national and decentralized levels directly affects the degree to which the private sector is involved, the adequacy of human, material, and financial resources made available, and the extent to which sociocultural attitudes are able to block efforts to improve PAC.

The legal/policy framework presents other challenges. Women and girls are less likely to use PAC services if they fear prosecution under laws that punish patients and providers for abortions not legally permitted. Women and girls also face hostility from the community, and many service providers view abortions as inherently criminal or immoral, rather than medical in nature—a view reinforced by the fact that abortion is regulated primarily through the criminal code.

Laws and national policy alone do not translate into accessible, quality services, so implementation through operational policies is essential. The region has experienced considerable progress in developing FP/RH policies, norms, and protocols (PNPs) that incorporate PAC. However, efforts to implement PNPs must critically examine and change related policies, such as personnel or logistics systems, or secure commitment at higher levels to lend needed support and resources.

In Francophone Africa, the policy environment for addressing abortion issues is extremely challenging. Even those countries that have made the most progress toward institutionalizing PAC have faced difficulties: some countries have defined PAC in health policies or documents but have not laid out plans for implementing PAC services, while others have provided emergency services for obstetrical complications but have not formally provided for PAC in health PNPs. In countries where PAC services have not been formally introduced, the policy environment challenges have yet to crystallize.

POLITICAL COMMITMENT

As mentioned earlier, PAC does not seek to increase access to abortion; rather, it seeks to ensure that abortion complications are treated. The principal objective of PAC is to prevent repeat abortions by providing patients with counseling and access to FP methods and other RH care options.

Effective Reproductive Health Programs: Foundation for PAC

Effective RH programs are the foundation for PAC. Those who set the country's priorities, allocate national and subnational resources, and influence the course of donor investments must be committed to strengthening RH programs. Laws and policies, including PNPs, need to be implemented and enforced, and coherent and practical strategies and action plans must accompany planning documents. Administrative units responsible for services should be given sufficient authority to influence increasingly decentralized governments.

All Francophone countries have formal government programs that expressly and implicitly address maternal and reproductive health and FP. The legal/policy framework has improved measurably in many countries through the efforts of national and subnational officials and a growing number of RH advocates in parliaments and in civil society. These efforts

have become increasingly visible over the past few years as advocates and service providers in the Francophone region have improved communication and networking, strengthened their skills for advancing RH agendas in their respective countries, and used the indisputable evidence of demand for RH, particularly for FP.

National and Decentralized Decision Making

Efforts to build political commitment at the national level are critical, but they are equally important at the regional, district, and community levels, where most countries have formally decentralized their government administrative units to place resources closer to communities. RH and PAC issues must be effectively presented to these units to receive attention and support. Local decision makers need accurate, timely, and up-to-date information about the level and characteristics of the unmet need for FP, the poor health status of women in general, the impact on their children, best approaches to improving maternal health, including PAC, and the specific policy and program actions that need to be taken.

Public and Private Sector Collaboration

RH needs, and PAC needs in particular, can only be met through mobilizing public and private sector resources. Government resources are scarce and need to be reserved for the most vulnerable segments of the population, while the private voluntary and commercial sectors need to target those who can effectively be served outside the public health system. Policymakers need to take specific legislative, regulatory, and policy actions to engage the private sector in PAC policy or planning.

Human and Financial Resources Allocated to PAC

The three West African countries that have introduced PAC services —Burkina Faso, Ghana, and Senegal—now need to institutionalize PAC programs. To do this, national and subnational leadership will need to reorder priorities and allocate adequate human, material, and financial resources for essential PAC components—preservice and in-service training, monitoring and supervision, and an equipment and supply system integrated into other essential commodity systems and sustained through private sector participation. Those countries that plan to introduce PAC are primarily focused on securing sufficient resources to conduct operations research to advocate for PAC.

Sociocultural Realities

Strong commitment among decision makers who are equipped with appropriate skills, knowledge, and tools can help to mitigate conflicting sociocultural realities that inhibit efforts to increase resources and expand services. Leadership and direction can also help to overcome the reluctance of service providers, including managers of hospitals and other health facilities—individuals who are essential to a viable PAC program. While the generally negative attitude toward abortion can hamper public dialogue on PAC, a degree of compassion and support for girls and women exists upon which committed and knowledgeable leaders can build advocacy and resources for PAC.

THE LEGAL/POLICY FRAMEWORK

Laws and policies alone do not ensure access and quality, but without them, it is difficult to institutionalize programs. Through the work of nongovernmental organizations (NGOs) affiliated with the International Planned Parenthood Federation, FP has been included in all national health programs in Francophone Africa. Some countries are developing PNPs for RH programs and are integrating PAC services into them as defined at ICPD. Some countries are now integrating PAC into their RH strategies and including PAC in their "minimum package of services." Other countries, such as Niger, are using emergency obstetric care as the organizing principle for PAC.

Several policies still need attention. The 1920 French colonial law prohibiting contraceptive propaganda must be amended so that decision makers and health care providers can support and promote FP services. Explicit policies must be instituted that allow girls and women suffering from abortion complications to seek help. Health codes need to be revised where they either conflict with other laws, are too broad to guide PAC, or fail to provide guidance where exceptions are permitted for legal abortions, such as those to save the life of a pregnant girl or woman. Health professional regulations need to be revised or clarified to remove restrictions on who may provide certain kinds of FP and PAC services,

and professional codes of conduct need to be consistent with health codes and related laws affecting PAC.

Translation of National Laws and Policy into Action

A supportive legal/policy framework does not automatically benefit women and girls in need. National laws and policies need to be translated into operational policies that govern service delivery at the local level and implemented through a responsive and realistic process. Some countries have done this by integrating PAC into service protocols, minimum service packages, and in-service training programs.

Policy Implications of Integrating PAC into Health Programs

Several sections of this report describe the necessary components for quality, long-term, and sustainable PAC services. Each component has public policy implications that must be considered and possibly changed to ensure that each is institutionalized and sustainable. For example, a myriad of public policies affect health budget resource allocation, the assessment of training needs, how personnel are deployed throughout the country, the adequacy of logistics and the supply system, the frequency and value of supervision, the "minimum package of services," and other critical issues. These policies must be reviewed to ensure that they support rather than undermine the successful integration of PAC. Moreover, the operational policies, regulations, rules, and other dispositions in the public sector need to be analyzed for how they influence service delivery in the private sector.

Planning Process

The process by which national laws and policies are implemented is as critical as the final strategic planning documents themselves. Simply stated, if plans are to be responsive and realistic, then leaders must be committed to grounding them in accurate and recent data, facilitating a participatory approach so all stakeholders are involved throughout the process, and taking a strategic approach in selecting what is feasible and practical to achieve with the available human and financial resources.

ADVOCACY TO IMPROVE THE POLICY ENVIRONMENT FOR PAC

Policy Objectives and Steps in Advocacy

This section provides insights into advocacy strategies that can be tailored to the identified policy objective. Advocacy is generally defined as a process to produce a policy action (i.e., it is not undertaken in the absence of a clearly defined policy objective). Thus, advocacy is distinguished from awareness raising and information, education, and communication activities, which generally have other purposes or audiences.

Given the heightened sensibilities and controversial nature of abortion in Francophone Africa, first steps in PAC advocacy are defining, clarifying, and prioritizing specific policy actions that are practical and feasible. These steps require a detailed review of the obstacles to introducing or expanding services and the underlying policy issues, including the absence of laws and regulations or ambiguity in those that exist. It also requires an understanding of the favorable and opposing forces on both sides.

While PAC presents some unusually difficult challenges, the underlying principles of advocacy in the area of RH are applicable and are well developed in a number of resource documents.* PAC advocacy has been successful in Francophone Africa for limited policy objectives: formally introducing PAC in the public sector, authorizing different cadres of health care professionals other than physicians to provide key services, and modifying preservice training. Francophone countries are now starting to advocate for more ambitious policy objectives, such as resources to train and equip additional PAC service sites.

Strategies Used in the Region for PAC and Related Themes

Advocacy will be successful when it is supported with operations research, demonstration projects, and best practices. Successful advocacy also requires the engagement of the highest possible decision makers early in the process so they will understand the need and cost-effectiveness of PAC and commit to ensuring that programs will be implemented, repli-

* Examples include *An Introduction to Advocacy: Training Guide* by Ritu Sharma and *Networking for Policy Change: An Advocacy Training Manual* by the POLICY Project.

cated, provided with additional resources, and institutionalized by policy change or action.

Lessons can be drawn from successful advocacy strategies used in related areas in Francophone Africa, such as female genital cutting, FP, and HIV/AIDS, all of which present their own controversies and sensitivities. Networks of NGOs, journalists, parliamentarians, women's groups, and leaders from major religious institutions have all become engaged in advocacy. The key to success is to identify the particular concern of each group, such as women's reproductive rights, vulnerability of adolescents, and maternal mortality, and assist them to organize supporting data and tailor messages to specific audiences. Selected community and traditional practitioners who exhibit understanding and concern for unwanted pregnancies can be enlisted to reach local decision makers and then trained in the principles of advocacy and the art of persuasive presentation.

Photo: Danielle Baron/CCP

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Introducing a Model for Postabortion Care

Putting Postabortion Care on the Maternal Health Agenda

Many reproductive health (RH) practitioners in Francophone Africa already understand the need for quality postabortion care (PAC) services and the benefits such services would provide, but they often face great opposition to reorganizing or initiating new services according to the PAC model for a number of reasons. First, induced abortion is often severely restricted and is always controversial—and most decision makers prefer to avoid controversy. Some also fear that providing improved treatment, or any treatment at all, will encourage more women to undergo clandestine abortions. Finally, in resource-poor countries, women who have chosen to have an illegal abortion are considered a low priority.

> *"Emphasize women's health and safe motherhood to reduce the stigma associated with abortion complications."*
>
> **— Dakar, 2002**

While these obstacles are undeniably formidable, presenting PAC within the safe motherhood framework is a strategy that works. Francophone Africa has very high maternal death rates, and countries have been struggling, with little success, to reduce these rates. Quality PAC is a relatively simple, effective, and cost-efficient way to lower maternal death rates; it is provided at one point in time to women in immediate danger, saving lives that would otherwise be lost. Counseling and family planning (FP) services can help reduce unplanned pregnancies and the need for induced and repeat abortions. PAC clients, already at the hospital with an unmet need for RH information and FP methods, can be easily targeted to receive counseling and FP services. Finally, the equipment, skills, services, and systems that make a quality PAC program are also essential to a quality safe motherhood program. Indeed, the long-term goal for program managers and policymakers should be to institutionalize PAC as a basic element of maternal and child health.

In appealing to providers and administrators in health facilities, numerous additional benefits of the PAC model can be cited. Complications from abortion and miscarriage account for a substantial percentage of

hospitalizations, which uses an enormous amount of scarce resources. Improving and reorganizing services to provide holistic care as recommended at the 2002 Dakar Conference, particularly with the introduction of manual vacuum aspiration (MVA), can greatly reduce costs to both the hospital and the patient and leave more resources available for other needs while increasing women's access to treatment.

Because only a few countries in Francophone Africa have established PAC programs, a main focus of the conference was an exchange between experienced countries and countries who want to begin the process of advocating and introducing PAC. PAC pioneers from Burkina Faso, Ghana, and Senegal facilitated plenary sessions in which they shared their experiences of introducing and scaling up PAC services. Other sessions detailed the basic requirements for delivery of the PAC model: emergency treatment, FP, and links to other kinds of RH care.

Basic Elements of Postabortion Care

COUNSELING

> ***"Counseling is a dialogue. PAC counseling goes beyond family planning to include medical, social, economic, and emotional problems."***
>
> **— Dakar, 2002**

Counseling plays an essential role in all aspects of PAC. From the moment a woman arrives at a health facility, she and her providers need to communicate. Care can only be considered high quality if a woman is informed of what is happening before, during, and after a uterine evacuation procedure. In addition, women should be counseled on FP, sexually transmitted infections (STIs), follow-up care, warning signs requiring medical attention, and any other issue that might be necessary for their return to good health. It is important to train providers in counseling prior to introducing MVA, because a tendency exists to equate PAC with MVA, viewing PAC simply as a new medical technique rather than a holistic service for treating patients. Providers must learn to recognize and respond to the psychological, emotional, and physical needs of the patient and maintain a nonjudgmental attitude. As one provider trained in Ghana remarked:

> At the beginning, our attitude toward the clients was not good; when we saw a young girl with a problem, the insults began. But now we encourage them, and we try to put ourselves in their place. (Taylor, 2002)

In his mini-university presentation on FP counseling at the 2002 Dakar Conference, Dr. Isaiah Ndong (EngenderHealth) outlined the main elements of a training curriculum, where providers learn to evaluate counseling needs, provide necessary information, and allow women to make an informed choice (EngenderHealth, 2003). The training emphasizes the importance of confidentiality, privacy, and dignity and addresses the values and behaviors of providers, appropriate timing for messages, and other RH needs.

EMERGENCY OBSTETRIC CARE

To manage incomplete abortions, providers must be able to prevent and manage sepsis, evacuate the uterus, and stop bleeding. These skills are paramount to emergency obstetric care (EOC) as well as other hospital emergency services.

To prevent or manage sepsis, health care facilities must take proper measures to prevent infections. Even if a hospital makes no other changes, training providers in proper techniques of preventing infections will improve health outcomes for all patients, including those requiring EOC. The HIV/AIDS crisis has made providers and decision makers more aware of the need for sterile environments and equipment.

MVA is the recommended method for uterine evacuation in uncomplicated, incomplete abortions because, among other reasons, it is simple to use and does not require general anesthetic or extensive recovery time. In addition to learning how to perform the procedure, providers must learn new ways to manage a woman's pain.

During the conference, participants cited the lack of MVA equipment as a major barrier to implementing or institutionalizing the PAC model in their country and recommended that MVA kits be included in the list of essential equipment for health facilities. In many locations, MVA equipment is restricted, unavailable, or prohibitively expensive.* In response, some experts emphasized that integrated PAC services should not depend only on MVA. Dilation and curettage (D&C) performed by skilled providers to treat incomplete abortion or complications can be

* Since the conference took place, Ipas has established three new African MVA distributors in Cameroon, Côte d'Ivoire, and Senegal; this is expected to increase access to and facilitate sustainability of MVA equipment. USAID does not support the purchase and distribution of MVA kits for any service.

part of a high-quality PAC program, when accompanied by the other elements described here. Country representatives were advised to strengthen services using available resources, rather than wait until MVA equipment becomes more easily available.

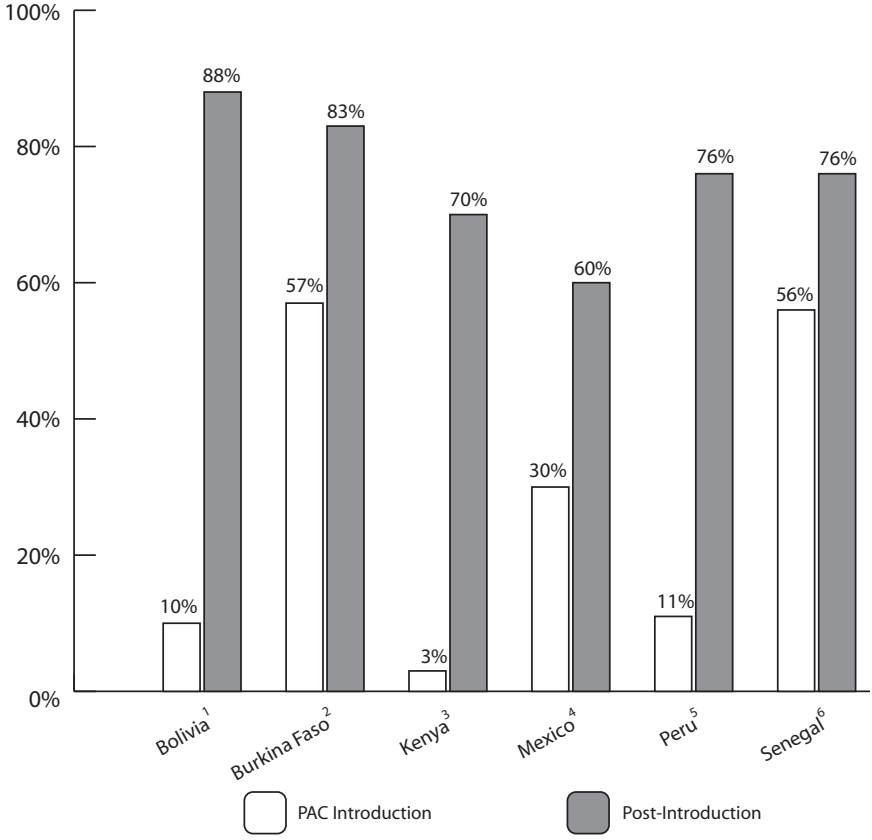
FAMILY PLANNING

Family Planning (FP) is important for all women, particularly those who have experienced an abortion. Discussions at the 2002 Dakar Conference concentrated on how to integrate FP services into the larger framework of emergency obstetric and maternal health care. During one session, participants discussed advocating to offer emergency contraception as an option for women who are motivated to avoid unwanted pregnancies, regardless of whether they are using another form of contraception.

Studies have shown that women are most likely to begin using an FP method if they can immediately obtain it at the time of their PAC treatment, instead of returning for another visit or being referred elsewhere to obtain it. In Kenya, for example, Solo et al. (1999) found that FP provided on the ward was adopted by 92 percent of women, as opposed to 54 percent of women who had to travel to a separate site. Ideally, FP counseling and services should be provided on the emergency ward by the same providers. Even if this is not possible, steps should be taken to ensure that no woman who wants a contraceptive method goes home without one. One possibility is to combine postpartum and postabortion FP as a routine service provided to women prior to discharge.

Programs introducing PAC in sub-Saharan Africa and other developing countries have shown great increases in contraceptive adoption rates over prior levels, as shown in Figure 2 on the opposite page. However, less is known about continuation rates. Some prospective longitudinal studies have been conducted, for example, in Egypt and Zimbabwe. In the Zimbabwe study, Johnson et al. (2002) found that more women used effective methods of contraception, fewer unplanned pregnancies occurred, and fewer repeat abortions were performed at the intervention site than at a comparison hospital. However, these longitudinal studies may face several obstacles, including high loss to follow-up and difficulty maintaining confidentiality.

Figure 2
Percentage of Postabortion Care Patients Obtaining a Contraceptive Method



Sources:

[1] Bolivia: Diaz et al. (1999).

[2] Burkina Faso: Ministry of Health, Burkina Faso. (1998).

[3] Kenya: Population Council/Africa OR/TA. (1999).

[4] Mexico: Langer et al. (1999).

[5] Peru: Benson & Huapaya. (2002).

[6] Senegal: Centre de Formation et de Recherche en Santé de la Reproduction & Clinique Gynecologique et Obstetricale, Centre Hospitalier Universitaire le Dantec. (1998).

LINKAGES TO OTHER SERVICES

PAC is contingent on other RH services, and the necessary links must be established. The most obvious links are with FP (including emergency contraception); the prevention, detection, and treatment of STIs (including HIV); infertility in the case of repeated miscarriages; and, of course, all programs dealing with maternal morbidity and mortality. The links with RH activities are expressly cited in the definition of PAC adopted by the PAC Consortium. Through these links, PAC can make an even greater contribution to improving the health of populations.

Steps in Initiating a Postabortion Care Program

A number of sessions at the conference focused on introducing PAC services, either at the national level or at the regional or local level as the PAC program becomes decentralized. In their roundtable session on the stages of PAC program development, Dr. Fatimata Diabate (CRESAR-Mali) and Dr. Isaiah Ndong (EngenderHealth) outlined the basic conditions and actions necessary to introduce, expand, and institutionalize PAC services in a given country. The following were identified as essential components for introducing PAC:

- A local champion who remains actively involved from the decision to introduce the new model of services through the full adoption of the program by appropriate stakeholders;
- Advocacy to explain the necessity, simplicity, and benefits of PAC services;
- Respect for clients' rights by officials, administrators, providers, and others;
- A vertical program at the outset to clearly demonstrate the effect of the new service model;
- Few sites initially to ensure high quality through concentrated efforts and to ease supervision;
- An intensive introduction phase, perhaps an operations research study or a pilot project with a rigorous evaluation component, accompanied by sufficient external technical assistance and financial support;
- Training by qualified, experienced trainers;
- Intensive monitoring and supervision to ensure that providers continue to apply their new skills and identify any potential barriers to success of the intervention; and
- Equipment and supplies required for all services.

METHODS FOR INTRODUCING PAC

Operations research (OR) is a method used to identify and solve program problems. OR examines the supply side of programs, and OR data is used to improve existing services or introduce new services (Fisher et al., 1991). As mentioned in the previous section, OR (with a quasi-experimental design) is a method often used to introduce the PAC model into a country. In Francophone Africa, OR has been used successfully to introduce the PAC model in Burkina Faso and Senegal.

The Burkina Faso and Senegal case studies—presented by Celeste Marin (Tulane University/FRONTIERS), Dr. Andre Jules Bazie (CRESAR-Burkina Faso), and Thierno Dieng (CEFOREP)—illustrate a number of advantages to using the OR approach. Even after several years of advocacy by a wide range of participants, PAC faced strong opposition from health officials in both countries. A compromise was finally reached, first in Burkina and then in Senegal, to allow national and international organizations to conduct an intervention study in several university teaching hospitals under the direction of the ministries of health (MOH) and education (MOE). The experimental nature and limited duration of an OR study required a lower level of commitment by authorities—knowing they could easily discontinue or distance themselves from PAC services if necessary increased the comfort level of decision makers wary of exposing themselves to controversy.

When the studies demonstrated the many benefits of the PAC model, MOH policymakers were quick to recognize the value of the intervention as a maternal health strategy and assumed ownership for the expansion and institutionalization phases. OR evidence, including cost data, also provided a basis for incorporating PAC into national policies, norms, and protocols. OR is a process also suited to improving and scaling-up programs. Ghana, Kenya, and Senegal have all tested approaches to decentralize PAC services, including training nurse-midwives to provide services in rural health facilities without direct physician supervision. In Ghana, Billings et al. (1999) found that training midwives is a feasible and acceptable way to decentralize PAC services, and training midwives who work at primary-level centers and physicians from district hospitals increases referrals and strengthens linkages between the two levels.

Cost information is particularly important for decision makers at both the policy and facility levels. Unlike many public health interventions, the PAC model actually leads to direct and indirect cost savings. Many OR studies introducing PAC services have included some assessment of

costs, and most have demonstrated substantial savings in terms of time, resources, and opportunity cost over previous treatment of women presenting with abortion complications. In particular, cost reduction has been attributed to the reduced lengths of hospitalization associated with the use of MVA (Ministry of Health, Burkina Faso, 1998; Centre de Formation et Recherche en Santé de la Reproduction & Clinique Gynecologique et Obstetricale, Centre Hospitalier Universitaire le Dantec, 1998; Brambila, Garcia, & Heimburger, 1998; Benson et. al., 1998).

Small-scale pilot or demonstration projects are also recommended for introducing PAC to demonstrate its feasibility to health professionals and decision makers. Pilot projects allow providers to test the PAC model and to adapt it to their local situation by identifying and resolving potential problems and refining the intervention before scaling it up.

4

Building Provider Competencies

Treatment of Abortion Complications

A number of presentations at the 2002 Dakar Conference examined the skills providers need to deliver quality postabortion care (PAC) services. First and foremost, provider competency should focus on the three core components of PAC. Ideally, PAC policies, norms, and protocols (PNPs) should identify the core components in which the provider needs to be proficient, and training in these skills must be made available to the provider. Efficient management of services, infection prevention, and program monitoring and evaluation also have a profound effect on competency.

In plenary and roundtable sessions, Professor Yolande Hyjazi (JHPIEGO), Dr. Isaiah Ndong (EngenderHealth), and Dr. Joseph Taylor (Ministry of Health, Ghana) spoke about training midwives in PAC, including manual vacuum aspiration (MVA), as a way to conserve resources and ensure greater access to care. In this way, physicians treat only complicated cases and are free to provide other services requiring their technical expertise, while women can be attended to more promptly than they had been previously. This division of labor makes PAC particularly well suited for expansion to lower levels of the health system, where a physician with dilation and curettage (D&C) skills may not be available. Midwives and nurses can treat routine cases of incomplete abortion closer to where women live and continue to refer those requiring more skilled attention to hospitals.

COUNSELING

Within an environment of privacy and confidentiality, a competent provider will:

- Understand and acknowledge the client's rights;
- Consider the client's cultural context;
- Use appropriate language tailored to the age of the patient;
- Provide care in a nonjudgmental manner;
- Remain unbiased and sensitive to the needs of the client;
- Be an active listener;
- Understand nonverbal communication; and
- Refer the patient if care is outside of the provider's scope of practice.

TREATMENT OF EMERGENCY COMPLICATIONS

The provider should be able to competently perform an initial assessment of the clinical status of the patient and recognize serious complications, such as shock, hemorrhage, intra-abdominal injury, or sepsis that may accompany abortion complications. Once immediate life-threatening complications are ruled out, the provider should solicit information regarding the patient's menstrual history, bleeding and cramping, and potential passage of tissue. A physical examination, including a pelvic exam via speculum and/or bimanual examination, provides other important information regarding the nature of the pregnancy, size and position of the uterus, and cervical dilatation. It is only after this thorough evaluation that the provider completes treatment of emergency complications using MVA or, if necessary, D&C.

It is important that providers master the capacity to talk with patients in a supportive, confidential, and nonjudgmental manner. Throughout the exam, diagnosis, procedure, and recovery process, providers should give complete information to patients to reduce anxiety.

Following treatment, the provider should ensure that each woman understands the potentially immediate return of fertility and the risk for pregnancy as well as danger signs following PAC treatment. A follow-up visit at the same facility or at a center that may be more convenient to the woman's home may be scheduled.

INFECTION PREVENTION

The provider should minimize the risk of disease transmission to himself or herself and to the patient through meticulous use of infection prevention measures. These measures include proper use of sterile and clean gloves, appropriate and sterile instruments, and no-touch technique for the MVA procedure.* Ensuring that sound infection prevention measures are taken is a team effort among health facility staff requiring input from clinicians, housekeepers, and administrators.

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* Using no-touch technique for MVA procedures means that no instrument that enters a woman's uterus can contact contaminated surfaces before insertion through her cervix. Specifically, the tenaculum, cannula, or dilator tips should not touch the providers' gloves, the patients' vaginal walls, or unsterile areas of the instrument area.

Table 2
Medicines for Postabortion Care
(To be adapted by each country according to the level of care)

Classes of Medicines	Frequently Used Medicines
Anesthetics	■ Atropine ■ Diazepam ■ Lignocaine 1% without adrenaline
Analgesics	■ Acetylsalicylic acid ■ Ibuprofen ■ Paracetamol
Antibiotics	■ Derivatives of penicillin ■ Ampicillin ■ Chloramphenicol ■ Metronidazole ■ Tetracyclines ■ Sulfamethoxazole ■ Sulfamethoxazole-trimethoprim
Antiseptics	■ Chlorhexidine ■ Betadine
Disinfectants	■ Bleach ■ Formaldehyde ■ Glutaraldehyde
Uterotonics	■ Ergometrine (injected and by bone) ■ Oxytocin injection ■ Misoprostol (future and promising)
Antirhesus globulin	
Antitetanus serum and vaccine	
Blood for transfusions	
Intravenous solutions	■ Glucose ■ Ringer ■ Sodium chloride ■ Potassium chloride

* Misoprostol spares between 30% and 40% of MVAs or curettages. The drug is inexpensive and eliminates risk of uterine perforation. Side effects include: nausea, vomiting, diarrhea, and pain requiring analgesia.

PAIN MANAGEMENT

> *"Place the patient at the center of pain management."*
>
> **— Dakar, 2002**

Pain management for women undergoing treatment for abortion complications should be systematic and thus is an important element of provider competency. Effective pain management minimizes anxiety and discomfort and the overall health risk to patients. In their mini-university session, Dr. Lamine Cissé (CEFOREP) and Dr. Blami Dao (CRESAR-Burkina Faso) outlined the key elements of effective pain management during PAC. Providers who competently perform a history, physical exam, and diagnosis using positive provider-patient communication can usually ensure effective pain control. In most situations, patients with incomplete abortion can remain comfortable during treatment with minimal intervention. The key steps to effective pain management are:

- Supportive attention from staff before, during, and after the procedure, including verbal anesthesia or "verbocaine";
- Gentle, yet confident technique; and
- Selection of an appropriate level of pain medication (e.g., nonsteroidal anti-inflammatory medications and injection of a paracervical anesthesia).

Postabortion Family Planning Counseling and Services

Some health facilities that deal with abortion-related emergencies may not offer family planning (FP) services, so providers will be required to learn new skills. To offer PAC services, providers must be able to help a patient understand the factors that lead to unwanted pregnancy and decide whether she wants a contraceptive method. If the patient does want a contraceptive method, the provider must help her choose an appropriate method and understand its correct use. PAC services should not depend on acceptance of FP, and all women should be able to make a free and informed choice.

The competent provider combines a foundation of FP clinical knowledge with solid counseling skills and should:

- Understand and consider the cultural and personal factors that affect a woman's decision to use FP;

- Provide information and counseling about methods as well as their characteristics, effectiveness, and side effects;
- Understand the choices among methods and the limits of each method;
- Provide correct information on the use of a chosen method;
- Provide counseling on dual protection to prevent transmission of sexually transmitted infections (STIs), including HIV/AIDS;
- Explicitly explain that the patient can become pregnant again in as little as two weeks; and
- Refer the patient for appropriate follow-up care or methods not immediately available (e.g., voluntary sterilization).

LINKAGES BETWEEN POSTABORTION EMERGENCY SERVICES AND OTHER REPRODUCTIVE HEALTH CARE

In his mini-university session, Dr. Kampatibe Nagbandja (Advance Africa) highlighted the link between STIs and PAC. The woman seeking PAC services is often overlooked for counseling and identification of STIs, including HIV/AIDS, due in part to the urgency that accompanies the need for treatment and the fact that bleeding can make identifying an STI difficult. Providers should consider PAC services as opportunities to identify and treat STIs and encourage women to seek voluntary counseling and testing for HIV.

OTHER AREAS THAT AFFECT PROVIDER COMPETENCY

Providers should be aware that PAC patients may require services unrelated to abortion complications. In his presentation on minimum competencies for PAC provision, Dr. Marcel Vekemans (IntraHealth) addressed several topics that complement and complete quality PAC services. Facilities should have appropriate equipment and adequate, private space for counseling, treatment, and recuperation. The maternity coordinator or PAC services coordinator should collect and analyze service delivery statistics on PAC and use this information for decision making. Finally, a comprehensive PAC program should involve the community in preventing and treating incomplete abortions. Activities that reach the community include information campaigns to inform the community of danger signs and the need for referral, community organization of transport systems and village funds for referral of complications of pregnancy and childbirth, and FP counseling to prevent unwanted pregnancies.

Preservice and In-Service Training

Preservice and in-service training systems include complementary approaches that are best used as linked components of a single, coordinated approach to strengthen the quality and sustainability of PAC services. Because this strengthening process requires time, in-service training is used to develop provider competencies, improve performance, and develop clinical training sites. As graduates leaving preservice institutions add to a national pool of providers, the need for in-service training will decline. Links between the two, such as involving staff from preservice institutions in in-service training, will help strengthen the training system.

THE BENEFITS AND CONSTRAINTS OF AN EFFECTIVE PRESERVICE TRAINING SYSTEM

The preservice audience includes all health providers. The advantage of a preservice training program is that, once established, it can reach a relatively large number of providers at one time, and the longer learning period is advantageous for mastering skills. A preservice training program is costly in the beginning, as resources—curricula, reference manuals, equipment, and clinical training sites—must be obtained or developed. Human resource development for preservice training is also more complex because faculty and clinical instructors must update their own knowledge and skills. Moreover, permitting students to master MVA is sensitive for many countries. These issues and the high cost of developing a PAC preservice training have been addressed through use of an on-the-job training system.

Photo: Marilyn Noguera/FPLM/JSI

THE CONTRIBUTION AND CONSTRAINTS OF AN EFFECTIVE IN-SERVICE TRAINING SYSTEM

In-service training systems have been a very successful part of pilot PAC programs. In general, in-service training has an immediate impact on the capacity of providers and access to services. Sites may also see an improvement in other areas of service delivery: the overall orga-

nization of sites may improve; sites may realize overall improvements in infection prevention; and provider attitudes and approaches may soften. In-service training also helps to develop clinical training sites to support preservice education.

Off-site, group-based training is costly and disruptive to a facility sponsoring participants. On-the-job training (OJT) is one approach that complements and addresses the constraints of group-based training. An OJT approach focuses on the learner at his/her site and ensures that learning takes place under real conditions. The time to achieve competency may be longer, but is, after all, a function of the caseload at trainees' worksites. Ultimately, the facilities must assume a greater share of the costs for OJT and ownership of training activities.

Supportive Supervision and Performance Improvement for Quality Assurance

Agencies that have used training as the sole intervention to address quality of services for many years would argue that a host of other factors affect site and individual performances and that training in itself is insufficient. Quality assurance should include effective supervision, sufficient supplies and equipment, appropriate infrastructure, and management of services. Several presentations at the 2002 Dakar Conference focused on elements of supervision and performance quality improvement as ways to improve and maintain the quality of PAC services. In their presentation on quality assurance and linkages to other reproductive and sexual health services, Dr. Isaiah Ndong (EngenderHealth) and Dr. Cheikh Cissé (Hôpital le Dantec/Dakar) presented several tools and approaches that can be applied to assure the quality of PAC services. Among these are effective supervision, the client-oriented, provider-efficient (COPE) approach, a cost analysis tool, and quality measurement. Mr. Pape Gaye (IntraHealth) and Dr. Manuel Pina (JHPIEGO) described the process of performance improvement and its application to PAC services.

EFFECTIVE SUPERVISION

Supervision is a process of guiding, helping, training, and encouraging staff to improve its performance to provide high-quality health services. Effective supervision facilitates team building and motivates providers to give high-quality services consistently. Supervisors apply leadership techniques to:

- Identify standards of good performance and effectively communicate them to staff members;

- Work with staff to periodically assess their performance in comparison to standards;
- Provide feedback to staff about their performance;
- Work with staff and the community to identify appropriate interventions that will lead to improved worker performance and delivery of high-quality health services; and
- Mobilize resources from many different sources to implement interventions.

CLIENT-ORIENTED, PROVIDER-EFFICIENT (COPE) APPROACH

The COPE approach is a results-oriented approach that encourages and enables facility staff and supervisors to assess the services they provide from the client's perspective (EngenderHealth, 1995). Using various tools, they identify problems, find root causes, and develop effective solutions. This process of self-assessment makes personnel aware of good practices because the assessment guides are based on international standards. The self-assessment approach creates involvement and ownership in the quality-improvement process.

COST ANALYSIS

A cost analysis tool measures the direct costs of providing specific health services, including the cost of staff time spent in direct contact with clients as well as the costs of commodities, expendable supplies, and medications (EngenderHealth, 2000). Managers can use this information to distribute human and other resources more efficiently and to set user fees for different services that reflect actual direct costs.

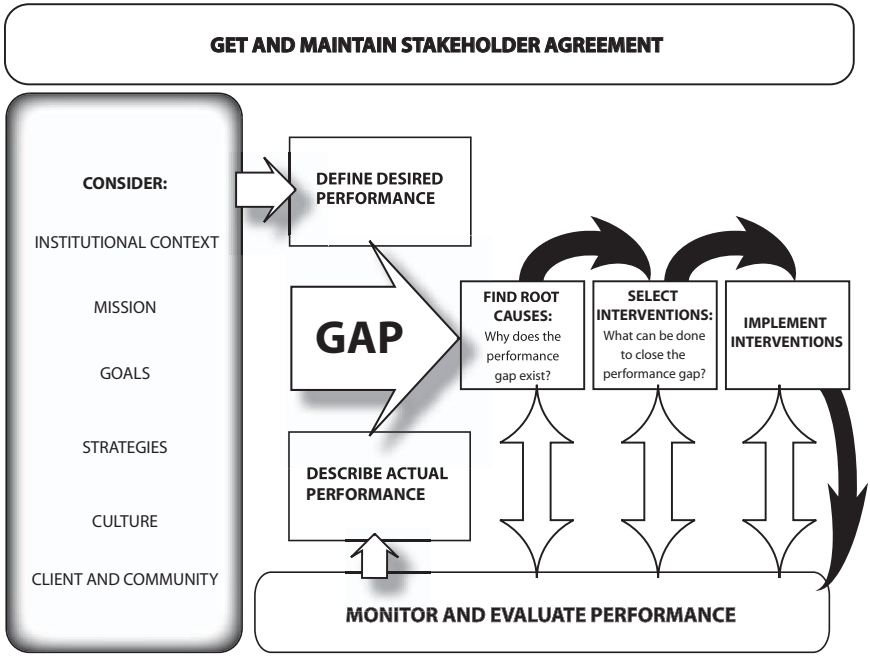
PERFORMANCE IMPROVEMENT

Performance improvement (PI) is a process designed to provide high-quality, sustainable health services (Caiola & Sullivan, 2000). The process considers the institutional context, describes desired performance standards, identifies gaps between desired and actual performance, identifies root causes, selects interventions to close the gaps, and measures changes in performance. The PI process is a valuable approach when applied to

PAC services. It puts an emphasis on results instead of inputs and helps to ensure a better return on investment and training activities.

The PI framework is illustrated in Figure 3 below (see Appendix for a description of each PI step). The PI process can identify factors that contribute to desired performance and identify how to strengthen them and help ensure transfer of training to the workplace.

Figure 3
Performance Improvement Framework



Source: The performance improvement definition and framework are products of a collaborative effort among members of the Performance Improvement Consultative Group. This group consists of representatives of USAID-funded cooperating agencies.

The Principle Steps in Applying Performance Improvement to PAC Services: Results from Senegal

Service providers at Roi Baudoin Hospital in Guèdiwaye, Senegal, outside Dakar, have applied the PI process to improve the quality of PAC services. During the initial step, providers, supervisors, and community representatives worked together to define standards of performance. Though desired performance results were based on national norms and service delivery guidelines, participants suggested ways to create higher standards.

Based on these standards, participants developed a performance observation tool to measure actual performance and to develop an action plan to remedy performance gaps. At the time of the 2002 Dakar Conference, Roi Baudoin providers were implementing this intervention. The PI approach will enable PAC providers to measure their performance and take action to maintain quality PAC services.

5

Scaling-Up, Institutionalizing, and Decentralizing

Preparing to Decentralize Postabortion Care

By and large, the first health care settings that have benefited from the introduction of postabortion care (PAC) are concentrated in urban centers and are relatively high up in the health care system, such as at the referral-hospital level. The geographic expansion of PAC into new regions or throughout an entire country and its integration into primary health care and into communities should make high-quality PAC services accessible to the entire population. By definition, PAC should also guarantee access to services, from family planning (FP) and the use of contraceptive methods to prevention of abortion and unwanted pregnancies.

Passing from the experimental/investigatory environment, where large amounts of energy and resources are already invested, to health facilities with fewer human and material resources, poses huge challenges, as does continuing these activities after the initial period of experimentation. To confront these challenges, the following questions must be addressed:

- How can we best replicate a successful experiment in other areas and at other times?
- How can we assure the continuity of existing activities?

Decentralization consists of two types of peripheral responsibilities: managing activities at the district level (or province, prefecture, or other term used in a given country) and delivering services at local levels.

Management at the district level reflects the overall organization of health services in the country. In both the public and the private sectors, more and more responsibilities are being delegated to regional structures, including various types of decision making, management of budgets and finances, supervision, stocking of medicines and supplies, and data collection. Thus, with regards to PAC, the role of the district and of the district's chief medical officer will be of primary importance.

Service providers should understand PAC and be trained (or retrained) and supervised. All service providers having reproductive health (RH) re-

sponsibilities are affected—from the head of the obstetrics and gynecology department to all nurses, midwives, matrons, traditional birth attendants, and village health extension agents. Any decentralization must maintain high-quality care, including quality medical and psychological management, respect for ethical considerations and confidentiality, and respect for preventing the transmission of infections at the time of service.

Decentralizing PAC service delivery to the local level eventually requires a system of referral and counter-referral that connects all levels of health structures, from local hospitals to peripheral services (small clinics, dispensaries, health posts, and health huts) and to communities without health structures (villages, rural areas, or city suburbs).

To reach local communities, it is important to establish, to the extent possible, direct contact with women of childbearing age and their partners as well as influential people in the family, such as mothers-in-law. At this stage, the objective is to eliminate, or at least reduce, the well-known causes that delay emergency interventions—namely, the time needed to identify a problem, make a decision, and find transportation and the time needed for the health care system to take charge. The success of these efforts depends on a functional referral and counter-referral system.

The communities, for instance, could organize emergency transportation services and village funds to be ready for the actual services. They need to obtain the support of local authorities and influential people ("the decision makers"); the heads of local groups (especially women's groups and youth groups); relevant nongovernmental organizations (NGOs); administrative, religious, and traditional leaders; and all those likely to promote PAC and RH education, such as sports clubs, worksites, and schools.

ROLE OF ADVOCACY

Advocacy is important at all stages of scaling-up, institutionalizing, and decentralizing PAC. As noted above, the policy objective needs to be clear at each stage so that the various target audiences understand precisely what actions they are being asked to take.

Numerous obstacles exist when introducing PAC into countries where abortion is illegal because most people link PAC to abortion. Where PAC is clearly distinguished from abortion, the environment is more receptive to its introduction and institutionalization.

The decision to decentralize PAC must come from the central level. It is a decision that involves the ministry of health (MOH) and, thus, the government. Advocacy is important in obtaining this commitment—advocacy based on the success of pilot programs in the major and/or university hospitals in the country and based on the success of similar programs in neighboring countries and in the rest of the world. The 2002 Dakar Conference provided ample evidence of such success stories. In addition to clinical pilot programs, advocacy events, such as national PAC days, are recommended to rally national and regional stakeholders to support and participate in expanding access to PAC services.

PAC must be well organized and complete—that is, it includes FP counseling and other RH care—to serve as a model. The successful introduction of quality PAC services should be documented and the results made available to decision makers and providers at peripheral health structures. Special studies and accurate data collection (and accompanying data-collection tools) will be a necessary part of the process. In-depth studies of the experience by independent observers and the MOH are also indispensable in generating support for bringing PAC to scale.

PLACING PAC WITHIN A COUNTRY'S HEALTH PROGRAMS

The objective behind institutionalizing PAC is to assure its sustainability by carefully defining all of its components and including them in the planning activities at the different levels of the health system. The easiest way to place PAC within a country's health programs is to incorporate it into the policies, norms, and protocols (PNPs) for managers and service providers. The PNPs should describe categories of personnel, structures involved, issues specific to the public and private sectors, and availability of equipment, supplies, investigatory techniques, and medicines. Institutionalizing PAC in each country would start with defining the PNP that codify the conditions of use and the clinical procedures by type of medical personnel and by level in the system.

PAC was integrated into the larger framework of emergency obstetrical care (EOC) in Senegal through the institutionalization of PAC PNPs. Thus, PAC was not considered a separate clinical activity that would require an approach and human resources beyond those already existing in the health system. In Burkina Faso, Ghana, and Senegal, the people developing the PNPs focused on the need to reduce the excessive workload of health personnel and the high costs of managing abortion complications.

A special emphasis was placed on the tasks assigned to the different categories of health workers and the reorganization of services to maximize available resources. Midwives and nurses were involved at every stage of the process, alongside physicians.

TRAINING

Preparing providers to implement quality PAC services requires training. Most PAC training has been in-service training at national- and regional-level health facilities, though it is slowly making its way to the district level in some countries, including Senegal. Ghana has integrated PAC into preservice education of health personnel. This has great advantages but requires changes in the medical, nursing, and midwifery school training curricula, which takes time and serious political commitment at the ministerial level.

The training content consists of clinical management (including counseling on attitudes toward youth, single people, and couples), certain aspects of sexual violence, pain management, prevention of infections in hospitals and other health care settings through thorough sterilization and disinfection, and RH components that are related to PAC. It is important also to include psychosocial aspects, such as the emotional state of patients, worries related to infertility and health, fear of legal repercussions and social stigmatization, and the dignity, comfort, and free expression of patients. Explanations should be provided throughout each step of the procedure. Job aids, such as checklists of clinical procedures and illustrated flipbooks for counseling, have been recommended to support providers and reinforce new skills.

Scaling-Up and Decentralizing Postabortion Care

PAC advocacy events involving partners and decision makers are a good way to launch the expansion of a PAC program. At the very least, preparing and circulating a short document synthesizing the national policy regarding PAC and the system of medical decentralization in the country could help to engage stakeholders. Hospital medical directors and administrators, the heads of health centers and health posts, and all participants in the initiative—donors, cooperating agencies, consultants, and leaders of NGOs and associations—will benefit from this summary.

The next steps will be to develop a strategy with the MOH (and sometimes with the ministry of education [MOE]) and a plan of action with

local stakeholders. It will be important to involve as many stakeholders in these steps as possible. Developing a strategy will lay out the necessary training and retraining courses according to the levels involved, and it will assure the availability of precise PAC protocols and equipment and supplies.

Introducing PAC successfully in one or more university or referral hospital(s) is an indispensable step on the road to decentralization. The introduction process begins with a needs assessment of existing services, provider skills, and equipment at the pilot hospital(s). The following are examples of the kinds of clinical issues for treating abortion complications that will have to be examined:

- Techniques of uterine draining (preferably manual vacuum aspiration [MVA], but also curettage and cleaning);
- Emergency vaginal or cervical clearing;
- Safe transfusions;
- Immediate problem management;
- Uterine atony treatment in late-term abortions;
- Management and prevention of infections;
- Treatment of lacerations (or poisonings in the case of some induced abortions); and
- Diagnosis of extrauterine and molar pregnancies.

Expansion will be progressive. One or two districts will be pilot sites. Action research and operations research will collect baseline data that can be compared to a district that had no intervention, monitoring over one or two years, trainings, supervision, referral and follow-up system, and community involvement.

Sites must be carefully chosen, keeping in mind the capacity to act, the amount of available funding, and the presence of a referral hospital that successfully practices PAC. At the peripheral levels, providers can be trained to recognize danger signs and stabilize and refer patients according to protocols. At this level, a precise diagnosis will not be made because it is often difficult to distinguish between a complete or incomplete miscarriage, an extrauterine pregnancy, a molar pregnancy, and pathologies not related to pregnancy, such as endometriosis or expulsion of a myoma.

The choice of intervention sites will take into consideration the wishes of local service providers and their willingness to participate, especially at

the levels of the health directorate and of the hospitals, which constitute the pillars of the initiative and are in charge of, or at least involved in, organization, training, and clinical courses.

EFFECTIVE SERVICES

Making PAC sustainable within the health care system requires a service that responds quickly, efficiently, and effectively to the client. Tasks and responsibilities must be clearly defined and assigned, including management of MVA supplies, dilation and curettage (D&C) services, and other drug supplies. PAC is most often an emergency service, and the chosen sites must be ready 24 hours a day, seven days a week. Integrating PAC effectively into EOC requires serious resource planning to assure high-quality patient management. Indeed, to provide PAC, facilities might need to restructure their services.

D&C requires more staff members (anesthetists, nurses, and technicians) than MVA. Conversely, the service provider spends more time with a patient for MVA treatment than for a D&C. Moreover, several providers at the 2002 Dakar Conference remarked that the extra workload necessary to counsel patients makes it difficult to provide good counseling in an emergency setting consistently. This extra workload could be absorbed by training and equipping not just doctors to perform MVA, but also midwives and nurses.

Photo: Danielle Baron/CCP

MONITORING AND EVALUATING PAC

Quality assurance and supportive supervision can be built into PAC and other RH programs to reduce costs and enhance the sustainability of PAC. Though supervision is necessary, it is often hard to organize in developing countries because of lack of adequate funds, personnel, and transportation. New techniques are currently being studied, including both peer supervision and "intervision," which consists of discussions among peers with the option to call in specialists as needed. In Senegal, for example, these techniques are practiced at all levels of the health system, and each health district has an RH supervisor to monitor RH activities.

Although some indicators were designed to measure the effectiveness and quality of PAC services, developing more specific indicators would improve monitoring. PAC-specific indicators should emphasize maintaining or improving the quality of care and services and assuring continuity of care. Monitoring and evaluation of PAC should also cover referral and counter-referral systems. The conditions for referral and counter-referral are spelled out in the protocols. Referral documents with pictograms for the most peripheral settings with nonliterate providers (matrons and village birth attendants), are distributed to assure that each health facility level is informed of the outcome of a patient referred from the previous level.

TECHNOLOGY AND INSTRUMENT SUSTAINABILITY

Defining the technology that is most appropriate for various institutional levels in a country is a decision made when medical guidelines and standard treatment protocols are developed. MVA is an appropriate technology for uterine evacuation because it fits easily in the most sophisticated infrastructure settings and in most primary care settings. MVA instruments are both sophisticated and simple. The noiselessness and speed of the instruments are highly appreciated in high-level settings, and the easy manual operation and cleaning are favorite features in primary care settings. Providers need to be trained to use and maintain MVA instruments properly to ensure repeat utility.

Instrument sustainability is an essential component to ensure consistent, high-quality PAC services. Providers must have access to the proper instruments. The technology of the instrument must be appropriate to the setting where the service is provided, and the cost of the instruments must be affordable. The instruments must be available when needed,

and the provider must be trained in their use. This seemingly simple set of requirements masks a complex combination of forces that affects the sustainability of PAC services.

SUPPLY-RELATED POLICIES

Supplies

The uninterrupted supply of uterine evacuation instruments and other supplies is crucial to maintaining high-quality PAC services. To ensure this, an efficient system is needed to distribute supplies from the central purchasing office to peripheral and private facilities. Both supply management and requisition systems at the central level need to be in place and managed with care. Commercial distributors are very useful partners for ensuring instrument sustainability.

In Senegal, certain health care settings buy these products themselves, while others put them on patient prescriptions. The latter approach fails to guarantee availability of the products needed for treatment within a reasonable time frame, given patients' low purchasing power, while stocking the products within the setting risks the problem of cost recovery. Even so, the best solution would be for the health care settings to provide the needed products and develop an efficient cost-recovery system.

Cost

MVA instruments are not expensive to manufacture, but they require excellent quality control. Small measurement errors can result in vacuum loss or a cannula cut that is nonfunctional. MVA instruments are designed to conduct repeated procedures with no change in performance, allowing the cost of one instrument to be spread over numerous interventions. The resulting cost per intervention is so low that the poorest settings can afford to provide this lifesaving intervention. However, the initial funds needed to purchase the first instrument can be an obstacle that Ipas and other institutions are trying to mitigate.

Subsidies have greatly increased the accessibility of contraceptive products. The subsidies allow a patient who accepts a FP method to go home with an affordable contraceptive product. This approach, highlighted in a study in Kenya, has been helpful in improving FP coverage for patients suffering from abortion complications (Solo et al., 1999).

Registration and Licensing

Product registration and commercial licensing is necessary for products to be sold legally, otherwise they can only be used in a research context. Registration procedures vary from country to country—from no registration in some to very complex filing requirements in others. Many countries base their own requirements on those of the European Community and/or the U.S. Food and Drug Administration. A separate government institution that may be outside the MOH structure usually handles product registration.

MVA Supplies

Regarding MVA supplies, stocking systems are not yet clearly coded by the health authorities in the countries that have already experimented with PAC. These supplies are always furnished by partner institutions. No Francophone country seems to have yet officially authorized the delivery of MVA supplies. However, given the low cost of the syringes and cannulae, it would be advantageous to include them in the list of supplies and products set up by MOHs, as has been the case in Ghana.

Importation Regulations, Procedures, and Fees

Importation regulations and procedures and customs fees should be considered in the service-pricing structure and the service-delivery timeline to ensure instrument availability where needed. Customs regulations and fees are usually managed by a national trade regulations entity. Special importation statutes and/or fee exemptions can be negotiated by MOH leaders. Distributors are usually knowledgeable about importation procedures and duty fees.

Procurement and Distribution Systems

Distribution systems (commercial and public) are needed to make instruments available to urban and rural health centers and hospitals. Commercial distributors that specialize in supplying medical instruments and health care supplies are often the most cost-effective and reliable, and they are very experienced in dealing with product registration and customs procedures. The MOH may have a special department dealing with the procurement of health commodities and their distribution to public sector facilities.

Treatment Guidelines and Protocols and New Technologies

Influential pioneer users often define medical guidelines and treatment protocols and review new technologies for government regulatory institutions. These advisors are often associated with the MOE, and, therefore, are not in a position to effect policy changes within the MOH; rather, they play a major advocacy role in introducing new technologies and treatments.

Classification of Essential Services and Supplies

Healthcare systems control the priority care and services and define the medical expenses of the government through essential packages of services and instruments. These essential packages are the foundation for medical guidelines and standard treatment protocols. When a service has been defined as essential, it is easier to purchase equipment and define budget line items, both in the regular MOH budget and in international assistance support budgets.

COMMUNITY INVOLVEMENT

Extending PAC services to peripheral levels requires community involvement. The goal of community involvement is twofold: first, communities can help prevent obstetric emergencies by promoting FP; and, second, communities can learn to recognize complications related to abortion and miscarriage and respond to such emergencies in a timely way. Many countries have made significant steps toward building government infrastructures for obstetric emergencies. But in places where such infrastructure is lacking, local communities must establish practical and affordable systems of transport that are always ready. These systems may require motor vehicles, donkey carts, boats, or other means of conveyance. Village funds set aside for PAC emergencies are also helpful.

To engage community support for PAC, it is helpful to identify one leader, a highly motivated "champion," to direct the entire process in his or her area. The next step is to identify local partners, set up local teams, and begin advocacy with influential persons and decision makers. These would include village chiefs, traditional leaders, religious leaders, social workers, teachers, representatives of women's, youth, labor, and sports groups, and NGO leaders. Respecting local precedents is crucial and delicate. One false step can bring down an entire endeavor. Table 3 on the opposite page shows the ways in which involved communities can take charge of pregnancy complications and PAC.

Table 3
Leading Methods of Community Involvement in Managing the Complications of Pregnancies and Postabortion Care

- Identify a representative from the community
- Provide the community with information on the advantages of using the services
- Train matrons and other village or community health agents
- Raise community awareness of the danger signs, through matrons and other agents
- Establish a system of emergency transport that includes:
  - ▷ evacuation plan
  - ▷ funds for emergencies and reimbursements
  - ▷ mode of transport
  - ▷ means of evacuation
  - ▷ system to monitor women who have been evacuated

Scaling-up, institutionalizing, and decentralizing PAC is possible. It has already been successfully introduced in several sub-Saharan countries (especially Anglophone countries), both in the private sector (e.g., Kenya) and in the public sector (e.g., Ghana), including projects involving health care professionals other than physicians (e.g., Burkina Faso, Ghana, Guinea-Conakry, Kenya, and Senegal). Such an undertaking must be carefully planned and must go through the stages described above: advocacy at the national level; governmental decisions; pilot studies in large hospitals; establishing norms and protocols; deciding about decentralization and expansion; training and supervision; and community involvement.

6

Crosscutting Issues

Though international conferences provide forums for developing consensus and adopting platforms for action, the responsibilities of interpreting and translating these into programs and interventions remain with the state. Adequate resources and political will and commitment are required for promoting reproductive health (RH) in sub-Saharan Africa. The controversy surrounding issues such as abortion and adolescent sexuality have curtailed states' abilities to adopt strong policies and legislation; fear of cultural, political, and social opposition is a formidable obstacle. As a result, the role of other organizations becomes critical in promoting postabortion care (PAC). Increasing the ability of local organizations to take on the challenge of preventing unwanted pregnancies and addressing the complications of illegal abortions is critical given the gap in existing health care resources in this region of the world.

Currently in sub-Saharan Africa, it is not possible to discuss any aspect of RH without considering the dynamic of the HIV/AIDS epidemic. The potential risk of exposure to HIV/AIDS and other sexually transmitted infections (STIs) is significant among women requiring PAC services. Documented evidence also confirms an increase in sexual violence against women, especially among the young, the poor, and those in conflict and postconflict settings. The contribution of sexual violence to unwanted pregnancy must be addressed by and integrated into PAC services.

The Role of Local Organizations

Limited financial and technical resources available for PAC services present serious obstacles for local organizations. Despite these constraints, their role in promoting PAC within their missions' frameworks is critical. As acknowledged at the 2002 Dakar Conference, PAC requires not only health interventions but also advocacy, policy, and operations research to

reinforce improved management if women are to benefit from available services. Moreover, organizations implementing PAC programs must work to create an environment where women feel comfortable seeking these services. Local organizations can also explain the consequences that result from denying access to RH care in communities, particularly appropriate counseling and family planning (FP) services that prevent women from resorting to illegal abortions. Although these are integral parts of the PAC model, they can easily be neglected when PAC service providers must attend to the medical emergencies of women seeking PAC.

At the 2002 Dakar Conference, African regional organizations were given the opportunity to develop local projects based on PAC best practices. In a two-day workshop following the conference, members of the Pan-African Regional Technical Assistance Group (PARTAGE)—a network of health organizations with a wide range of institutional specialties and technical expertise—selected best practices to implement within the framework of their own activities. Based on ideas discussed at the conference, each organization prepared a proposal for a six-month project that included implementation and evaluation of strengthened FP within PAC activities. For example, the Senegalese nongovernmental organization Santé de la Famille is training its clinical providers to include counseling and information on FP within its PAC services.

Adolescents and Postabortion Care Services

Adolescents who seek PAC services often have different needs and experiences than adults. At the PAC Consortium meeting in November 2002, a working group was formed to specifically address the needs of adolescents by developing guidance for youth-friendly PAC services. At least 1 in 10 abortions worldwide is performed on women aged 15 to 19 years. As cited earlier, in many African countries, 70 percent of women treated for abortion complications are younger than 20. Each year, more than 4.4 million young women in this age group have an abortion, 40 percent of which are performed under unsafe conditions (United Nations Population Fund, 2001). Because they have limited access to confidential, quality RH care and information, including contraception, adolescents disproportionately suffer from abortion complications. When, and if,

adolescents use contraceptives, they often do not use them consistently or correctly, which leads to unwanted pregnancies and often to induced abortions. PAC program managers should ensure that their activities provide adolescents with appropriate access to confidential, high-quality services free from stigma and discrimination. Providers must ensure that youth are equipped with reliable methods to protect themselves against both pregnancy and STIs.

Communities and service providers must provide confidential and adolescent-friendly services that are accessible and affordable. In particular, unmarried adolescents may face stigma as a result of abortion. Counseling is particularly important because young females often report that their first sexual experiences are either forced or coerced by older partners. Treatment of abortion complications is critical to adolescents, especially because they tend to obtain abortions after the first trimester from unskilled providers. Self-induced abortion is common among adolescents in many countries. Adolescents seeking PAC also need access to

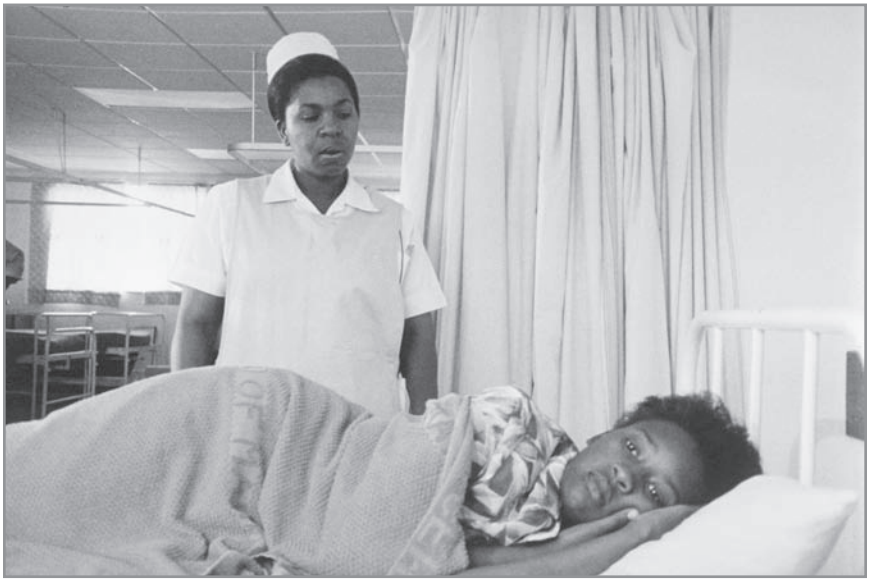


Photo: Carlyn Saltman/CCP

youth-friendly RH information and FP counseling that will allow them to make informed choices and avert repeat abortions. PAC for adolescents must also address other consequences of unprotected sex, especially STIs, and HIV/AIDS in particular.

Sexual Violence

Almost all countries in the world outlaw rape and are signatories to international and national legislations that address the question of gender-based violence. However, the burden of proof, shame, and stigma associated with reporting rape cases and the leniency of courts toward the perpetrators of rape crimes make it difficult for women to effectively protect themselves from sexual aggression. Both civil and customary laws in sub-Saharan Africa provide the victim limited support. Urbanization, the breakdown of extended family structures, and the use of drugs and alcohol can increase sexual and deviant antisocial behavior among male and, sometimes, female adolescents. Beliefs associated with cures for HIV/AIDS (e.g., intercourse with young girls) are also contributing to an increase in acts of sexual violence. These victims usually end up seeking abortion services and thus will require PAC.

Participants at the 2002 Dakar Conference discussed the social and health consequences of domestic and sexual violence. Rape—in many cases resulting from the recent civil conflicts in the region—often forces women to seek abortions (usually illegally) or give birth to unwanted children. To counter this problem, participants urged policymakers to enact appropriate laws and regulations to protect victims of sexual violence and punish perpetrators. Participants also supported female empowerment through education and male gender-equity awareness.

Sexually Transmitted Infections and Postabortion Care

Women who present themselves for PAC are clearly at potential risk for STIs, including HIV. The urgency of the situation often leads providers to concentrate on resolving the complications associated with abortion. Bleeding caused by the abortion can also hide obvious signs of some STIs, such as vaginitis and urethritis. During the 2002 Dakar Conference,

participants noted that opportunities to address issues such as STIs are lost if the interventions to address these issues are not strengthened.

The first recommendation made at the 2002 Dakar Conference was to adhere to strict infection control to avoid passing an infection from the client to the provider. Secondly, each PAC client should be counseled, diagnosed, and treated for STIs and her partner notified to avoid reinfection. This should be complemented by appropriate infection prevention measures. Finally, clients should be counseled and advised to go to a voluntary counseling and testing center for HIV. To the extent possible, the referral should be made directly from the PAC service center. Counseling to prevent future abortions should stress dual protection against unwanted pregnancies and STIs.

Dual Protection

Dual protection is an effective method for preventing unwanted pregnancies and STIs. Accurate utilization of this method prevents the need for abortions. Dual protection options include:

- Abstinence;
- Using a contraceptive method associated with mutual fidelity of uninfected partners;
- Using a condom and one other contraceptive method; and
- Always using a male or female condom.

Counselors and providers should promote dual protection for those seeking PAC. For those who cannot negotiate safe sex with their partners, counselors should emphasize ways for women to empower themselves and avoid situations that would risk their exposure to unprotected sexual intercourse. Dr. Marcel Vekemans (IntraHealth) further highlighted the link between STI prevention and PAC through his mini-university session on dual protection: as clients with unwanted pregnancies are often also at high risk for an STI, providers should encourage all PAC clients to use dual protection, including adolescents, women whose partners have risky behaviors, sex workers, or those living in areas where there is a high prevalence of HIV.

7

Conclusion

Understanding the Policy Environment

The discussions and subsequent action plans developed at the 2002 Dakar Conference reflect the concern throughout Francophone Africa for improving the policy environment as a necessary step for introducing or expanding postabortion care (PAC).

The characteristics of the policy environment in Francophone Africa must be considered to pave the way for sustainable PAC services. Most policy issues are common to all countries in the region. Therefore, if most Francophone countries identify, prioritize, and pursue similar policy issues, improvements in the policy environment may be accelerated. Countries can strategically share information on policy developments so all can benefit from the results and lessons learned by individual country efforts. However, countries need more assistance to develop effective strategies, engage additional colleagues, and develop concrete actions plans that have a specific component focused on policy issues.

Future Perspectives

Certain policy issues were raised but not discussed at any length during the formal proceedings of the conference. However, the following issues are important and require more discussion.

INVOLVE THE PRIVATE SECTOR

Governments often cannot afford to meet PAC needs. The sooner the private sector (voluntary and commercial providers) is invited to participate in policymaking and planning, the more likely countries will be able to mobilize additional human, material, and financial resources.

CONSIDER SOCIOCULTURAL FACTORS IN ADVOCACY

Advocates need to recognize and consider both punitive and supportive attitudes and practices. Some promising strategies have engaged religious leaders, women's organizations, parliamentarians, journalists, nongovernmental organizations (NGOs), and public officials in successful advocacy around sensitive and controversial areas, including female genital cutting and family planning. Many of these strategies can be adapted to PAC.

Next Steps for the Francophone Postabortion Care Initiative Committee

Since the 2002 Dakar Conference, the Francophone PAC Initiative Committee Secretariat has surveyed country delegations to ascertain progress made toward implementing their action plans. The results were presented at the meeting of the Society of African Gynecologists and Obstetricians (SAGO) in January 2003 in Bamako, Mali. Most countries had formalized their plans with ministry of health (MOH) authorities, yet political support and financial backing to implement the plans have been generally weak. Delegates cited the need for advocacy to promote the importance of PAC services and mobilize funds for equipment and training.

At the SAGO meeting, Francophone PAC Initiative Committee members gathered to discuss the initiative's next steps. To address the need for continued support for country action plans and for better communication and coordination among partners, the Centre de Formation et de Recherche en Santé de la Reproduction (CEFOREP) was nominated to coordinate the Francophone PAC Initiative, a role formerly played by IntraHealth. The roles defined for the coordinating agency (secretariat) are to:

- Collect information from countries and international partners regarding the introduction and extension of PAC (including information on policies, programs, agendas, results, partner activities, best practices, lessons learned, and new developments);

- Share information among partners and Francophone countries;
- Establish working relationships with regional institutions such as the West African Health Organization (WAHO), the World Health Organization, Regional Office for Africa (WHO/AFRO), Réseau de Recherche en Santé de la Reproduction en Afrique (RESAR), and other organizations that could assist with PAC advocacy; and
- Support countries in implementing action plans (identify potential funding sources and provide technical assistance to extend PAC programs and for preparing proposals, budgets, and monitoring and evaluation plans).

The goal of the secretariat is to ensure that the Francophone PAC Initiative is implemented. The four objectives are to:

- Establish a functional network of Francophone countries and institutions working in PAC;
- Collect and evaluate information related to introducing and extending PAC programs;
- Document and disseminate information in Francophone Africa through periodic bulletins and regional forums; and
- Support countries to implement their PAC action plans.

Expected results:

- Increased support from partners and regional institutions to implement PAC action plans;
- Improved collaboration on PAC among partners and regional institutions in Francophone countries;
- Increased participation of regional institutions in the Francophone PAC Initiative (RESAR, WAHO, and WHO/AFRO);
- Improved political environment for PAC in Francophone MOHs;
- Increased knowledge and use of PAC best practices and lessons learned; and
- Progress in implementing PAC action plans in Francophone countries.

The success of the Francophone PAC Initiative has demonstrated the need to share information and mobilize resources collectively to address the growing problems associated with the consequences of abortion complications in sub-Saharan Africa. The process of organizing this conference was an excellent example of collaboration that has relevance for all working in reproductive health in Francophone Africa. The cooperation of the international organizations was exemplary, and each brought its own expertise and resources to the conference to make it a meaningful exercise to the participants.

The PAC Consortium exemplifies the type of synergy that can be achieved and the outputs that can be generated when international organizations work together effectively. WHO's active involvement and support to the initiative was a key factor that led countries to participate in the initiative. CEFOREP's recent step to ensure that African coordination and leadership drives the initiative in the future will serve to create sustainability and empower countries to improve reproductive health outcomes for women throughout Francophone Africa.

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Appendix

Performance Improvement

I. Analyze Performance

A performance analysis identifies what gaps, if any, exist between actual and desired performance. This step focuses on the performance of an individual or a group. It may be necessary to define desired performance by asking the stakeholders to clarify the expectations of providers and to establish indicators for performance. Those involved in the process should take account of the institutional context and input from national policies and priorities, service delivery guidelines. They should obtain as much stakeholder involvement as possible including providers, supervisors and clients.

II. Find Root Causes

A root cause analysis asks why the identified performance gaps exist. Those engaged in the process of performance improvement gather information from as many stakeholders as possible and identify the causes of poor performance before selecting appropriate interventions. Common causes of poor performance can include:

- Unclear job expectations;
- Lack of performance feedback;
- Poor motivation;
- Weak management or leadership;
- Deficient knowledge and skills;
- Inadequate facilities, equipment or supplies; and
- Lack of client and community focus.

III. Select Interventions

The next steps are to select and design interventions to address the causes of performance gaps.

IV. Implement Interventions

During this phase, set interventions in motion and establish monitoring systems. Those engaged integrate the concept of change into daily work and carefully manage the direct and indirect impact of that change to maintain organizational effectiveness and achieve performance improvement goals.

V. Monitor and Evaluate Performance

The process of monitoring and evaluating performance is ongoing. Because certain interventions can have an immediate effect on organizational and individual performance, facilitators should be certain to initiate sound monitoring systems that focus on measurable change to obtain early feedback on the results of the intervention. To evaluate the impact of interventions on closing the performance gap, those involved can compare formal assessments of actual job performance to desired performance and use the information obtained from the evaluations to guide further analysis of performance gaps and root causes. Site stakeholders can follow leads from the information retrieved to modify the intervention design as needed.

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